FOR OHF USE

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022905

Facility Name: JOLIET TERRACE

Address: 2236 MCDONOUGH (Number) JOLIET (City) 60436 (Zip Code)

County: WILL

Telephone Number: (847) 647 - 5795 **Fax #** (847) 674 - 5794

IDPA ID Number: 36-2883283

Date of Initial License for Current Owners: 10/01/76

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) GENERAL PARTNER

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA/PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1
(Telephone) (847) 675-3585 Fax (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Print Previe

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	120	Intermediate (ICF)	120	43,920	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	36,036	4,085	1,129	41,250	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,036	4,085	1,129	41,250	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 93.92%

D. How many bed-hold days during this year were paid by Public Aid?
1,346 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Previe

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	162,453	12,595	6,905	181,953		181,953	0	181,953			1
2	Food Purchase		143,278		143,278		143,278	0	143,278			2
3	Housekeeping	148,539	15,387	0	163,926		163,926	0	163,926			3
4	Laundry	41,228	15,465	3,013	59,706		59,706	0	59,706			4
5	Heat and Other Utilities			62,791	62,791		62,791	75	62,866			5
6	Maintenance	48,407	26,792	16,960	92,159		92,159	10,467	102,626			6
7	Other (specify):*			6,850	6,850		6,850	0	6,850			7
8	**TOTAL General Services**	400,627	213,517	96,519	710,663		710,663	10,542	721,205			8
	B. Health Care and Programs											
9	Medical Director			3,250	3,250		3,250	0	3,250			9
10	Nursing and Medical Records	1,002,262	31,944	7,719	1,041,925		1,041,925	926	1,042,851			10
10a	Therapy	98,005		4,563	102,568		102,568	0	102,568			10a
11	Activities	65,183	2,904	1,250	69,337		69,337	0	69,337			11
12	Social Services	0		1,225	1,225		1,225	0	1,225			12
13	Nurse Aide Training			0				0				13
14	Program Transportation			0				0				14
15	Other (specify):*							0				15
16	**TOTAL Health Care and Progra**	1,165,450	34,848	18,007	1,218,305		1,218,305	926	1,219,231			16
	C. General Administration											
17	Administrative	84,477		351,747	436,224		436,224	(318,380)	117,844			17
18	Directors Fees			0				0				18
19	Professional Services			55,921	55,921		55,921	11,906	67,827			19
20	Dues, Fees, Subscriptions & Promotions			17,240	17,240		17,240	(1,880)	15,360			20
21	Clerical & General Office Expense	26,896	13,662	96,336	136,894		136,894	(54,547)	82,347			21
22	Employee Benefits & Payroll Taxes			236,559	236,559		236,559	0	236,559			22
23	Inservice Training & Education			0				60	60			23
24	Travel and Seminar			1,279	1,279		1,279	0	1,279			24
25	Other Admin. Staff Transportation			18,741	18,741		18,741	476	19,217			25
26	Insurance-Prop.Liab.Malpractice			43,974	43,974		43,974	1,132	45,106			26
27	Other (specify):*			0				6,999	6,999			27
28	**TOTAL General Administration**	111,373	13,662	821,797	946,832		946,832	(354,234)	592,598			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,677,450	262,027	936,323	2,875,800		2,875,800	(342,766)	2,533,034			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Previe

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			102,421	102,421		102,421	(12,091)	90,330			30
31	Amortization of Pre-Op. & Org.			2,424	2,424		2,424	0	2,424			31
32	Interest			125,239	125,239		125,239	(33,211)	92,028			32
33	Real Estate Taxes			30,103	30,103		30,103	1,430	31,533			33
34	Rent-Facility & Grounds							0				34
35	Rent-Equipment & Vehicles			23,855	23,855		23,855	3,922	27,777			35
36	Other (specify):* IME			9,000	9,000		9,000	(9,000)				36
37	TOTAL Ownership			293,042	293,042		293,042	(48,950)	244,092			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers							0				39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			65,880	65,880		65,880	0	65,880			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers			65,880	65,880		65,880		65,880			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,677,450	262,027	1,295,245	3,234,722	0	3,234,722	(391,716)	2,843,006			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Previe

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(13,487)	30		9
10	Interest and Other Investment Income	(34,621)	32		10
11	Discounts, Allowances, Rebates & Refunds		2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties		21		18
19	Entertainment	0	20		19
20	Contributions	(132)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(983)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	(985)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	8,203	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (42,005)		$	30

OHF USE ONLY								
48		49		50		51	52	

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(349,711)	SCHED	34
35	Other- Attach Schedule	0	TTACHED	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (349,711)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (391,716)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Previe

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.

The amounts in columns F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

STATE OF ILLINOIS — **Page 5A**

Facility Name JOLIET TERRACE

ID# 0022905

Report Period Beginning: 01/01/2000

Ending: 12/31/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference
	The information listed in B13 thru G43 is from Page 5.		
1	**Day Care**	0	0
2	**Other Cars for Outpatients**	0	0
3	**Governmental Sponsored Special Programs**	0	0
4	**Non-Patient Meals**	0	2
5	**Telephone, TV & Radio in Resident Rooms**	0	0
6	**Rented Facility Space**	0	34
7	**Sale of Supplies to Non-Patients**	0	10
8	**Laundry for Non-Patients**	0	4
9	**Non-Straightline Depreciation**	(11,487)	30
10	**Interest and Other Investment Income**	(34,621)	32
11	**Discounts, Allowances, Rebates & Refunds**	0	2
12	**Non-Working Officer's or Owner's Salary**	0	0
13	**Sales Tax**	0	2
14	**Non-Care Related Interest**	0	32
15	**Non-Care Related Owner's Transactions**	0	0
16	**Personal Expenses (Including Transportation)**	0	25
17	**Non-Care Related Fees**	0	20
18	**Fines and Penalties**	0	21
19	**Entertainment**	0	20
20	**Contributions**	(132)	20
21	**Owner or Key-Man Insurance**	0	22
22	**Special Legal Fees & Legal Retainers**	0	19
23	**Malpractice Insurance for Individuals**	0	26
24	**Bad Debt**	0	27
25	**Fund Raising, Advertising and Promotional**	(983)	20
26	**Income & IL Personal Property Replacement T**	0	0
27	**Nurse Aide Training for Non-Employees**	0	13
28	**Yellow Page Advertising**	(985)	20
29	**Non-Paid Workers**	0	0
30	**Donated Goods**	0	0
31	**Amortization Expense**	0	0
32		8,203	6
33			
34			
35			
36			
37			
38			
39			
40			
41			
42			
43			
44			
45			
46			
47			
48			
49			
50			
51			
52			
53			
54			
55			
56			
57			
58			
59			
60			
61			
62			
63			
64			
65			
66			
67			
68			
69			
70			
71			
72			
73			
74			
75			
76			
77			
78			
79			
80			
81			
82			
83			
84			
85			
86			
87			
88			
89			
90			
91			
92			
93			
94			
95			
96			
97			
98			
99			
100			
101			
102			
103			
104			
105			
106			
107			
108			
109			
110			
111			
112			
113			
114			
115			
116			
117			
118			
119			
120			
121			
122			
123			
124			
125			

Sch V	Adj. Summary
Line 1	0
Line 2	0
Line 3	0
Line 4	0
Line 5	0
Line 6	8,203
Line 7	0
Line 8	8,203
Line 9	0
Line 10	0
Line 10a	0
Line 11	0
Line 12	0
Line 13	0
Line 14	0
Line 15	0
Line 16	0
Line 17	0
Line 18	0
Line 19	0
Line 20	(2,106)
Line 21	0
Line 22	0
Line 23	0
Line 24	0
Line 25	0
Line 26	0
Line 27	0
Line 28	(2,106)
Line 29	6,189
Line 30	(15,487)
Line 31	0
Line 32	(34,621)
Line 33	0
Line 34	0
Line 35	0
Line 36	0
Line 37	(48,198)
Line 38	0
Line 39	0
Line 40	0
Line 41	0
Line 42	0
Line 43	0
Line 44	0
Line 45	(42,009)

Print Other Adjustment

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	75	0	0	0	0	0	0	0	75	5
6	Maintenance	8,203	0	1,553	711	0	0	0	0	0	0	0	10,467	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	8,203	0	1,553	786	0	0	0	0	0	0	0	10,542	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	926	0	0	0	0	0	0	0	0	926	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	0	0	926	0	0	0	0	0	0	0	0	926	16
	C. General Administration													
17	Administrative	0	(318,380)	0	0	0	0	0	0	0	0	0	(318,380)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	405	11,431	70	0	0	0	0	0	0	0	11,906	19
20	Fees, Subscriptions & Promotions	(2,100)	0	220	0	0	0	0	0	0	0	0	(1,880)	20
21	Clerical & General Office Expenses	0	5,677	(60,271)	47	0	0	0	0	0	0	0	(54,547)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	60	0	0	0	0	0	0	0	0	60	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	322	154	0	0	0	0	0	0	0	0	476	25
26	Insurance-Prop.Liab.Malpractice	0	298	767	67	0	0	0	0	0	0	0	1,132	26
27	Other (specify):*	0	2,280	4,719	0	0	0	0	0	0	0	0	6,999	27
28	**TOTAL General Administration**	(2,100)	(309,398)	(42,920)	184	0	0	0	0	0	0	0	(354,234)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	6,103	(309,398)	(40,441)	970	0	0	0	0	0	0	0	(342,766)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(13,487)	198	454	744	0	0	0	0	0	0	0	(12,091)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(34,621)	0	0	1,410	0	0	0	0	0	0	0	(33,211)	32
33	Real Estate Taxes	0	0	0	1,430	0	0	0	0	0	0	0	1,430	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	1,449	2,473	0	0	0	0	0	0	0	0	3,922	35
36	Other (specify):*	0	0	0	(9,000)	0	0	0	0	0	0	0	(9,000)	36
37	TOTAL Ownership	(48,108)	1,647	2,927	(5,416)	0	0	0	0	0	0	0	(48,950)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Cent	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(42,005)	(307,751)	(37,514)	(4,446)	0	0	0	0	0	0	0	(391,716)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe JOLIET TERRACE # 0022905 Report Period Beginning 01/01/2000 Ending 12/31/2000

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		E&S MANAGEME	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISE	LINCOLNWOOD	MGMT CONSULTANT
				IME REALTY	LINCOLNWOOD	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
V	17	MANAGEMENT FEES	$ 330,747	EMI ENTERPRISES	0	0	(330,747)	1	-330747
V								2	
V								3	
V	17	OFFICERS SALARY				12,367	12,367	4	12367
V	19	ACCOUNTING FEES				405	405	5	405
V	21	OFFICE EXPENSE				5,677	5,677	6	5677
V	23	TRANSPORTATION				322	322	7	322
V	25	INSURANCE				298	298	8	298
V	27	EMPLOYEE BENEFITS				2,280	2,280	9	2280
V	28	DEPRECIATION				198	198	10	198
V	35	AUTO LEASE				1,449	1,449	11	1449
V								12	
V								13	
Total			$ 330,747		0	$ 22,996	$ (307,751)	14	

* Total must agree with the amount recorded on line 34 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Previe

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	21	BOOKKEEPING	$ 81,783	EKS MANAGEMENT, INC		$	$ (81,783)	15	-81783
16	V								16	
17	V								17	
18	V	6	PAINTING SALARIES				1,553	1,553	18	1553
19	V	10	RN CONSULTANT SALARIES				926	926	19	926
20	V	19	PROFESSIONAL FEES				11,431	11,431	20	11431
21	V	20	WANT ADS				220	220	21	220
22	V	21	OFFICE EXPENSE				21,512	21,512	22	21512
23	V	23	SEMINARS				60	60	23	60
24	V	25	TRANSPORTATION				154	154	24	154
25	V	26	INSURANCE				767	767	25	767
26	V	27	EMPLOYEE BENEFITS				4,719	4,719	26	4719
27	V	30	DEPRECIATION				454	454	27	454
28	V	35	EQUIPMENT RENT				2,473	2,473	28	2473
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 81,783			$ 44,269	$ * (37,514)	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Previe

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		Sum_6B
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	36	OFFICE RENT	$ 9,000	IME REALTY CORP.		$	$ (9,000)	15	-9000
16	V								16	
17	V								17	
18	V	5	UTILITIES				75	75	18	75
19	V	6	REPAIRS & MAINTENANCE				711	711	19	711
20	V	19	PROFESSIONAL FEES				70	70	20	70
21	V	21	OFFICE EXPENSE				47	47	21	47
22	V	26	INSURANCE				67	67	22	67
23	V	30	DEPRECIATION				744	744	23	744
24	V	32	INTEREST				1,410	1,410	24	1410
25	V	33	RE TAX				1,430	1,430	25	1430
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 9,000			$ 4,554	$ * (4,446)	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Previe

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6C

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Previe

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Previe

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	BERNARD COHEN	GENERAL PART	ADMINISTRATION		SCHEDULE ATTACHED			MGMT FE	$ 21,000	17-3	1
2	MORRIS ESFORMES	GENERAL PART	ADMINISTRATION					SALARY	12,367	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 33,367		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Previe

the name(s)
PORTS.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8 | Show Pgs 8E thru 8 | Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES
Street Address: 3737 W. ARTHUR
City / State / Zip Code: LINCOLNWOOD, IL 60718
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	PATIENT DAYS	617,052	11	$ 185,000	$ 185,000	41,250	$ 12,367	1
2	19	ACCOUNTING FEES	PATIENT DAYS	617,052	11	6,053		41,250	405	2
3	21	OFFICE EXPENSE	PATIENT DAYS	617,052	11	84,917	64,123	41,250	5,677	3
4	25	TRANSPORTATION	PATIENT DAYS	617,052	11	4,810		41,250	322	4
5	26	INSURANCE	PATIENT DAYS	617,052	11	4,462		41,250	298	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	617,052	11	34,099		41,250	2,280	6
7	30	DEPRECIATION	PATIENT DAYS	617,052	11	2,964		41,250	198	7
8	35	AUTO LEASE	PATIENT DAYS	617,052	11	21,677		41,250	1,449	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 343,982	$ 249,123		$ 22,996	25

Print Previe

Print Page 8

STATE OF ILLINOIS

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: EKS MGMT,
Street Address: 3737 W. ARTHUR
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTING SALARIES	PATIENT DAYS	617,052	11	$ 23,229	$ 23,229	41,250	$ 1,553	1
2	10	RN CONSULTANT SALARI	PATIENT DAYS	617,052	11	13,856	13,856	41,250	926	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	617,052	11	170,994	131,341	41,250	11,431	3
4	20	WANT ADS	PATIENT DAYS	617,052	11	3,290		41,250	220	4
5	21	OFFICE EXPENSE	PATIENT DAYS	617,052	11	321,801	269,147	41,250	21,512	5
6	23	SEMINARS	PATIENT DAYS	617,052	11	905		41,250	60	6
7	25	TRANSPORTATION	PATIENT DAYS	617,052	11	2,302		41,250	154	7
8	26	INSURANCE	PATIENT DAYS	617,052	11	11,476		41,250	767	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	617,052	11	70,589		41,250	4,719	9
10	30	DEPRECIATION	PATIENT DAYS	617,052	11	6,797		41,250	454	10
11	35	EQUIPMENT RENT	PATIENT DAYS	617,052	11	36,988		41,250	2,473	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 662,227	$ 437,573		$ 44,269	25

Print Previe

Print Page 8

STATE OF ILLINOIS

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: IME REALTY CORP.
Street Address: 3737 W. ARTHUR
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	100	11	$ 1,685	$	4	$ 75	1
2	6	REPAIRS & MAINTENANC	INCOME	100	11	15,902		4	711	2
3	19	PROFESSIONAL FEES	INCOME	100	11	1,575		4	70	3
4	21	OFFICE EXPENSE	INCOME	100	11	1,047		4	47	4
5	26	INSURANCE	INCOME	100	11	1,504		4	67	5
6	30	DEPRECIATION	INCOME	100	11	16,647		4	744	6
7	32	INTEREST	INCOME	100	11	31,549		4	1,410	7
8	33	RE TAX	INCOME	100	11	32,000		4	1,430	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 101,909	$		$ 4,554	25

Print Previe

Print Page 8

STATE OF ILLINOIS

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Previe

Print Page 8

STATE OF ILLINOIS

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Previe

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LINCOLNWOOD FUNDING		X	MORTGAGE	$5,173.00	08/01/95	$ 1,795,000	$ 1,500,155	07/31/75	PRIME+	$ 100,621	1
2	LINCOLNWOOD FUNDING		X	LETTER OF CREDIT							23,843	2
3												3
4												4
5												5
	Working Capital											
6	INSURANCE FINANCING		X	INSURANCE FINANCING						PRIME +	775	6
7												7
8	RELATED PARTY										1,410	8
9	TOTAL Facility Related				$5,173.00		$ 1,795,000	$ 1,500,155			$ 126,649	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,795,000	$ 1,500,155			$ 126,649	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Previe

Facility Name & ID Numbe JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	32,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	31,203	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,397)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	31,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	30,103	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	34,117	8
	1996	32,125	9
	1997	32,600	10
	1998	32,235	11
	1999	31,203	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Previe

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,836 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1976	$ 100,000	1
2					2
3	TOTALS			$ 100,000	3

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

STATE OF ILLINOIS

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1976	1976	$ 1,233,000	$ 49,320	25	$ 49,320	$	$ 1,171,350	4
5											5
6											6
7	REL. PTY					1,396		1,396			7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	BUILDING IMPROVEMENTS			1979	3,802		10			3,802	9
10	BUILDING IMPROVEMENTS			1980	10,532		3			10,532	10
11	BUILDING IMPROVEMENTS			1980	7,500		10			7,500	11
12	BUILDING IMPROVEMENTS			1982	54,503	1,730	31.5	1,730		20,688	12
13	BUILDING IMPROVEMENTS			1983	2,495		10			2,495	13
14	BUILDING IMPROVEMENTS			1989	8,100	540	15	540		5,940	14
15	BUILDING IMPROVEMENTS			1990	19,140	608	20	957	349	9,092	15
16	BUILDING IMPROVEMENTS			1991	5,335	169	20	267	98	2,269	16
17	BUILDING IMPROVEMENTS			1992	17,257	549	31.5	549		4,155	17
18	BUILDING IMPROVEMENTS			1992	11,861	791	15	791		5,932	18
19	BUILDING IMPROVEMENTS			1993	4,065	129	31.5	129		879	19
20	BUILDING IMPROVEMENTS			1993	14,238	366	39	366		2,347	20
21	BUILDING IMPROVEMENTS			1994	5,200	133	39	133		671	21
22	FLOORING INSTALL			1995	9,823	252	39	252		733	22
23	ROOFING			1995	12,675	325	39	325		852	23
24	TILES			1996	15,503	397	39	397		1,042	24
25	FLOOR TILES			1998	23,132	593	39	593		896	25
26	ROOFING			1999	17,100	438	39	438		348	26
27	BLINDS/WALLCOVERING/WINDOW TREATMENTS			2000	19,897	2,843	20	497	(2,346)	497	27
28	COVE BASE			2000	2,679	77	27.5	77		77	28
29	SPRIKLER HEADS			2000	4,300	33	27.5	33		33	29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 60,689		$ 58,790	$ (1,899)	$ 1,252,130	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 317,122	$ 36,051	$ 29,099	$ (6,952)		$ 391,008	37
38	Current Year Purchases	48,812	7,077	2,441	(4,636)		2,441	38
39	Fully Depreciated Assets	229,507						39
40								40
41	TOTALS	$ 595,441	$ 43,128	$ 31,540	$ (11,588)		$ 393,449	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 103,817	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 90,330	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (13,487)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,645,579	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Previe

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the curre rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipm $ 12,455 Description: SEE SCHEDULE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	MAINT, ACTIVITY	98 CHEVY VAN	$ 650.00	$ 7,800	17
18	ACTIVITY	98 TOYOTA COROLLA	300.00	3,600	18
19					19
20					20
21	TOTAL		$ 950.00	$ 11,400	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Previe

ent

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Previe

our
ies.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Cost	Outside Practitioner (other than consultant) Units	Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs		$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Previe

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 116,092	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 55,000)	663,962		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	77,018		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	485,623		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,342,695	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	312,343		11
12	Long-Term Investments			12
13	Land	100,000		13
14	Buildings, at Historical Cost	1,233,000		14
15	Leasehold Improvements, at Historical Cost	269,137		15
16	Equipment, at Historical Cost	595,441		16
17	Accumulated Depreciation (book methods)	(1,775,253)		17
18	Deferred Charges	35,439		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 770,107	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,112,802	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 107,009	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	55,803		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,036		31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,500		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 217,348	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,500,155		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,500,155	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,717,503	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 395,299	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,112,802	$	48

***(See instructions.)**

Print Previe

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 264,352	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 264,352	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	307,217	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(176,270)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 130,947	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 395,299	24 *

*** This must agree with page 17, line 47.**

Print Previe

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,507,318	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,507,318	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	34,621	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 34,621	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**DISCOUNTS**		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 3,541,939	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 710,663	31
32	Health Care	1,218,305	32
33	General Administration	946,832	33
	B. Capital Expense		
34	Ownership	293,042	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	65,880	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,234,722	40
41	**Income before Income Taxes (line 30 minus line 40)****	307,217	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ 307,217	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Print Previe

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,316	1,371	$ 28,118	$ 20.51	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,701	7,456	134,253	18.01	3
4	Licensed Practical Nurses	17,083	18,333	327,484	17.86	4
5	Nurse Aides & Orderlies	46,810	49,002	417,635	8.52	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,693	9,547	98,005	10.27	8
9	Activity Director					9
10	Activity Assistants	8,404	8,722	65,183	7.47	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,663	19,876	162,453	8.17	15
16	Dishwashers					16
17	Maintenance Workers	4,960	5,070	48,407	9.55	17
18	Housekeepers	19,253	20,735	148,539	7.16	18
19	Laundry	5,735	6,187	41,228	6.66	19
20	Administrator	2,080	2,240	84,477	37.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,553	2,836	26,896	9.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,561	4,905	41,597	8.48	31
32	Other Health Care(specify)					32
33	Other(specify)	6,260	6,595	53,175	8.06	33
34	TOTAL (lines 1 - 33)	153,072	162,875	$ 1,677,450 *	$ 10.30	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

Print Previe

0

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 6,905	1-3	35
36	Medical Director		3,250	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		2,865	10-3	39
40	Physical Therapy Consultant		2,088	10a-3	40
41	Occupational Therapy Consultant		2,475	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		1,250	11-3	44
45	Social Service Consultant		1,225	12-3	45
46	Other(specify)				46
47	PSYCHO-SOCIAL CONSULTANT		975	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 21,033		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses	37	625	10-3	51
52	Nurse Aides	27	229	10-3	52
53	TOTAL (lines 50 - 52)	64	$ 854		53

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MICHAEL ROSEN	ADMIN		$ 12,000
DEBRA PATTY	ADMIN		2,500
THERESA OKUN	ADMIN		69,977
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 84,477

B. Administrative - Other

Description	Amount
EMI ENTERPRISES	$ 330,747
BERNARD COHEN	21,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 351,747
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA	DATA PROCESSING	$ 3,770
INTEGRATED INVENTORY	DATA PROCESSING	1,125
NURSING CARE SYSTEM	DATA PROCESSING	5,457
MID AMERICA	DATA PROCESSING	1,320
ALPHA CPX	DATA PROCESSING	44
KRUPNICK BOKOR	ACCOUNTING	11,100
MCBRIDE, BAKER	LEGAL	11,442
LAWRENCE SCHWARTZ	LEGAL	18,000
PERSONNEL PLANNERS	UC CONSULTANT	1,517
LINCOLNWOOD FUNDING	REMARKETING FEE	2,146
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 55,921

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,450
Unemployment Compensation Insurance	13,874
FICA Taxes	128,192
Employee Health Insurance	47,177
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	5,104
EMPLOYEE BENEFITS-OTHER	7,762
EMPLOYEE PHYSICAL EXAMS	0
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	0
RELATED PARTY	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 236,559

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	9,796
Health Care Worker Background Chec	250
(Indicate # of checks performed)	
ADV & PROMO/MARKETING	1,968
DUES & SUBSCRIPTIONS	4,359
LICENSES & PERMITS	735
TRUST FEES, CONTRIBUTIONS,etc.	132
RELATED PARTY	220
LESS TRUST FEES, CONTRIB, etc.	(132)
Less: Public Relations Expense	( )
Non-allowable advertising	(983)
Yellow page advertising	(985)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,360

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	0
RELATED PARTY	0
Seminar Expense	
EDUCATION & SEMINAR	1,279
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,279

* Attach copy of IMRF notifications

**See instructions.

Print Previe